Life and Death in SNFs: Ten Things You Need to Know About Advance Directives in Nursing Facilities

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**This is a recorded presentation.**
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Dr. Mims is board certified in family medicine and geriatrics with an expertise in clinical epidemiology and quality improvement. She is the Vice President and Chief Medical Officer for Medicare Quality Improvement for Alliant GMCF, the Quality Improvement Organization for Georgia. She serves as the current president of AHQA, the national trade association for QIOs.
Jane Pederson, MD, MS

Dr. Pederson provides leadership and clinical guidance to Stratis Health’s health care quality and safety initiatives. Jane is board certified in internal medicine and geriatrics and maintains a clinical practice in the long-term care setting. She is an active member a number of health care societies and committees, including the Minnesota Medical Directors Association and the Minnesota Medical Association. She serves on the Board of Examiners for Nursing Home Administrators and participates in state work groups the focus on topics relevant to older individuals. She received both her MD and completed her internal medicine residency at the University of Minnesota. In addition, she holds a MS in Health Services Research and Policy also from the University of Minnesota.
Ken Burgess, JD, Partner, PoynerSpruill

Ken Burgess is a health care attorney with nearly 30 years experience representing skilled nursing facilities, assisted living communities, hospices and home health agencies in N.C. and around the U.S. He is a frequent national author and lecturer on health care issues, including end of life and advance directives matters.
David Gifford, MD, MPH

David Gifford, MD, MPH serves as the American Health Care Association and National Center for Assisted Living’s (AHCA/NCAL) senior vice president of quality and regulatory affairs. AHCA/NCAL represents more than 11,000 for- and not-for-profit nursing homes and assisted living residences. He oversees AHCA’s quality initiative and serves as co-chair of board for Advancing Excellence. Dr. Gifford previously served as the Director of the Rhode Island Department of Health, as well as the Chief Medical Officer for Quality Partners of Rhode Island where he directed CMS’s national nursing home-based quality improvement effort. He is a board certified Geriatrician and has worked as medical director in several nursing homes. He completed his primary care residency and geriatric fellowship at the University of California in Los Angeles (UCLA) after graduating from Case Western Reserve University School of Medicine. While a Robert Wood Johnson Clinical Scholar, Dr. Gifford received his Master’s in Public Health (MPH) in Epidemiology from UCLA.
Life and Death in Skilled Nursing Facilities

Ten Things You Need to Know About Advance Directives in Nursing Facilities
After this session, participants will be better prepared to do the following in practice:

- Describe key issues in implementing advance directives (AD) policies and honoring residents’ end of life wishes
- Evaluate real life scenarios with real life outcomes
- Discuss 10 tactics to avoid problems and honor residents’ wishes
- Apply an “algorithm” to guide the decision making process
Resident admits from hospital where she:
- Was determined to be terminally ill
- Appropriate for palliative care/hospice
- Executed Universal DNR Order after “long” discussion by MD with resident and husband
- Incoherent at admission
- Husband speaks for her
- She has 12-year old HCPOA naming husband as agent
  - And it contains a clear direction to him re no life sustaining care
- Never revoked that document
- She came to us for “therapy” to improve mobility
- Only in facility 5 days – never became hospice-certified
Our Real Life Case

✓ At admission, husband says wife is no longer terminal
  - That was five days ago
  - Believes her admission for therapy means she’s not terminal
  - He wants her to be full code

✓ Admissions coordinator does not see Universal DNR Order, only HCPOA

✓ Creates white “face sheet” reflecting full code status

✓ 5 days later resident arrests near midnight
  - NA notifies nurse 1; She’s aware of the DNR Order in chart
  - She assesses and gives no CPR
  - Returns to nursing station to call husband; sends Nurse 2 to confirm status
Our Real Life Case

- Nurse 1 calls husband (4-9 minutes have passed now)
- He goes ballistic: “I made her full code; give her CPR”
- Nurse 1 returns to room and initiates CPR
  - Resident expires
  - Hospital /EMR records confirm death
- Admit date was 3/12/12
- Survey date was 3/18/13 – one year later
- Citations: IJ for quality of care
  - Facility failed to give CPR to a full code resident consistent with her expressed EOL wishes
  - Also got IJ for QA—not taking “deficiency” to QA
“We Got Trouble, We Got Pool”

✓ We got this IJ and the F520 deleted at IDR and CMS

✓ But, we got lucky

✓ Issues in these facts:
  ▪ At admission, we didn’t see Universal DNR Order
  ▪ We saw HCPOA
    o We didn’t read it and note conflict in it and Husband’s instructions
    o We didn’t recognize that H had no authority per the HCPOA to make his W a full code

  ▪ We create “full code” face sheet in chart with DNR/HCPOA and thus created the potential for nursing to mess this up
  ▪ We first properly honored resident’s no code wishes
  ▪ Then we panicked and gave her CPR
How We Prevailed

✓ CMS got this wrong
  ▪ Resident was not full code
    o If we made mistake in saying she was in chart, CMS made same one
    o Husband = no authority to override DNR or HCPOA direction
      • The HCPOA contained a mini-living will that restricted H’s authority
      • SOM IJ example = taking authority from one without legal authority
  ▪ Resident was no code:
    o She was terminal; had HCPOA saying no life-prolonging care; in 12 years, she never revoked it; she had 5-day old DNR order; and per the SOM, giving her CPR in face of DNR also = an IJ
  ▪ The chart conflict was a deficiency, but a “D” per CMS’s own 9/2012 SOM Guidance: no causative outcome because the resident was expired when we attempted CPR
1. Critical Steps During the Admissions Process

✓ Staff must, *adequately*, inquire into existence of ADs from competent resident/surrogate

- Must understand the different types of ADs in the state:
  - Health Care Power of Attorney
  - Living Will
  - General Durable POA With Health Care Powers
  - Portable DNR orders
  - MOST/POST/POLST Forms (standing physician orders)
Critical Steps During the Admissions Process

✓ Understand the distinctions in these documents under state law
  o What each does/does not do and limitations of each

✓ Be able to recognize inconsistencies in them

✓ Know how to resolve those issues:
  ▪ Notice to resident/family
  ▪ Conferences with MD, social worker, family
  ▪ Notification of facility superiors immediately of potential conflict and seek guidance
Critical Steps During the Admissions Process

✓ Understand/document “is this a competent resident or am I dealing with a surrogate?”

✓ Who is the surrogate?
  - Is the one claiming authority actually authorized?
  - If not, to whom, under any applicable AD or state law do we turn to for medical decision making?
Critical Steps During the Admissions Process

- Creating and maintaining a consistent chart re ADs and/or oral expressions of EOL wishes from admission forward

- CMS Guidance:
  - An inconsistent chart re ADs = “D” deficiency IF no negative outcome has occurred
  - It’s an “IJ” if:
    - Care requested is not given
    - Care declined is given
2. Implementing Advance Directives

✓ Process for ensuring ALL staff know residents’ AD status
  ▪ For immediate, consistent implementation
  ▪ Scurrying around looking for charts
  ▪ CMS Region IV: color coded indicators are fine
3. Contrary Surrogates

✓ Surrogates “directing” care *contra* to oral or written AD wishes of resident
  - Understanding state law on decision-making hierarchy
  - NC “family decision tree” statute as example
  - Poster to show: 1) staff and 2) family the sequence of authority

✓ Our case example: IJ deletion turned on this issue—was Husband an “authorized” surrogate AND acting within scope of his power?
4. Measure Resident Competency

- Court adjudications (rare)
  - If you have one, it will designate your surrogate

- Absent court adjudication, normal test in most states:
  - In opinion of appropriate licensed profession (MD, RN, social worker; psychologist, etc.) is resident able to MAKE and COMMUNICATE health care decisions and understand implications of accepting/declining care and/or alternatives offered
5. Limitations on Creation of ADs

- Family attempts to execute ADs for incompetent residents
- Family attempts to have incompetent or questionably competent resident execute or revoke ADs
- Facility attempts to do likewise
  - Believing this resolves family conflict
  - Or provides certainty
- The quarrelling family
6. When in Doubt, Don’t Delay

✓ Issues, doubts, uncertainties in:
  ▪ Resident’s EOL wishes
  ▪ Terms/content of ADs
  ▪ Surrogacy issues
    ○ Who is authorized surrogate
    ○ What is scope of their authority
    ○ Potential family conflicts

✓ Identify them/resolve early
  ▪ Not in crises
  ▪ Recall our earlier case example
7. “Don’t Forget About Me”

✓ Classic example: staff scurrying around looking for an AD or surrogate and call me
  ▪ Is the resident still competent?

✓ Cardinal rule: competent resident’s wishes always trump any AD
  ▪ Most ADs not legally effective until incompetence
  ▪ Exception: MOST/POST orders (MD orders)
    o Even here, resident’s contra stated choice must be resolved to avoid “lack of consent” issues
8. Which Lawsuit Do You Want To Defend?

Where uncertainties still exist, despite all of the above, ask this:

- Rather defend assault/battery case for giving unwanted care?
- Or wrongful death for withholding care?
- We always “default” to full care
- Complicating factor: CMS says that is an IJ deficiency if ADs direct different decision than we made
9. Who Can Declare Death?

- Know your state law on who can declare death
  - MD?
  - RN?
  - LPN?

- Impacts when/how long we offer CPR or other life-prolonging measures

- Sources: medical and nursing licensing statutes and/or website guidance (position papers)
10. Reassessing Competence

How often do we need to reassess this?

- Recall OBRA “change of condition” criteria
- Most state law is silent on this issue
- CMS is not
  - Change of condition
  - Choices expressed by resident/surrogate that differ from last documented choices
  - Some states: discharge from/admission to new care setting
CMS Guidance of Advance Directives and End of Life Resident Rights

- 9/27/13 CMS issued new surveyor guidance on EOL rights
- Repeats Patient Self-Determination Act & SNF regulations
- Stresses residents rights UNDER STATE LAW to make and have honored advance directives
- Imposes obligations on SNFs to have policies/procedures guaranteeing these rights
  - And educating residents about these rights
  - Inquiring about presence of ADs
  - Documenting ADs and EOL choices
  - Knowing who is authorized to give consent for EOL care
  - Honoring EOL wishes from an AD or an authorized surrogate
  - Incorporating resident choices into care / care planning
CMS Guidance of Advance Directives and End of Life Resident Rights

- New SOM guidance also gives examples of deficiencies and scope/severity level:
  - See our December 2012 Shorts on Long Term Care
  - And your handouts

- Immediate Jeopardy examples:
  - Resuscitating a resident with DNR order
  - Hospitalizing a resident contrary to expressed wishes
  - Taking direction/consent from unauthorized surrogate

- Contrast “D” level deficiency:
  - Facility fails to properly/consistently document resident’s wishes but no event has yet occurred that results in unwanted care
Algorithm Determine Person’s wishes

1. **Is person competent to make decisions?**
   - **Yes**: Ask Person
   - **NO**: Do they have Advance Directive?
     - **Yes**: Does it specify Healthcare proxy?
       - **Yes**: Is the HCP decisions c/w Advanced Directives?
         - **Yes**: Follow Person’s Decisions
         - **NO**: Challenge HCP
       - **NO**: Follow Healthcare proxy
     - **NO**: Does it specify decisions?
       - **Yes**: Follow Advanced Directive
       - **NO**: Ask Person
   - **Ask Person**
   - **Can they explain consequences of their decision?**
     - **Yes**: Seek informal HCP
     - **NO**: Follow Person’s Decisions
QAPI to Monitor Center’s End-Of-Life Practices

✔ Using QAPI principles to focus on Center’s end-of-life practices
Five Elements of QAPI

1. Performance Improvement Projects
2. Systemic Analysis & Systemic Action
3. Quality of Life
4. Quality of Care
5. Governance & Leadership
6. Design & Scope
7. Feedback, Data Systems and Monitoring
Organizational QAPI System

PDSA

Assess system

Formulate plan to change system

Pilot test change

Evaluate change

Review performance

Result

Disseminate within organization

Revise plan & Repilot test

YES

NO

YES

NO
Facility Metrics

QA committee Assess Performance (monthly)

- % individuals with Advance Directive, DNR, DNH
  - At admission and also 1 week after admission
  - Quarterly
  - By physician

- % of staff who can correctly name or rapidly find (<2 min) correct code status (e.g. DNR) on
  - random set of residents
  - 1 week after resident’s change their status
Example Physician Report about Advance Directives

Provide rate compared to other physicians:

<table>
<thead>
<tr>
<th>Physician</th>
<th># patients</th>
<th># Adv Directive</th>
<th>% with Adv Directive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ralston</td>
<td>25</td>
<td>5</td>
<td>25%</td>
</tr>
<tr>
<td>Dr Snow</td>
<td>10</td>
<td>1</td>
<td>10%</td>
</tr>
<tr>
<td>Dr Weber</td>
<td>2</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

List his/her patients with info about prescribing:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Adv Directive</th>
<th>DNH</th>
<th>DNR</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sallie Smith</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No POA named</td>
</tr>
<tr>
<td>John Davis</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No POA named</td>
</tr>
<tr>
<td>Mary Myers</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Husband POA</td>
</tr>
</tbody>
</table>
Strategies to assure awareness of residents end-of-life status

✓ Improve Communication
  ▪ Huddles
  ▪ Consistent Assignment

✓ Track performance on
  ▪ Obtaining advanced directives
  ▪ Staff awareness

✓ Provide feedback to physicians and staff
  ▪ QA&A Committee
  ▪ Engage Medical Director to communicate and provide feedback to physicians

✓ Develop system to allow ANY staff to rapidly identify resident’s
  ▪ Advance Directives
  ▪ Code status
  ▪ Healthcare proxy

✓ Allow staff to develop system
  ▪ Pilot test on unit
  ▪ Track compliance with system
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